



Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229



Amerigroup
PA Pharmacy Phone 800-454-3730
PA Pharmacy Fax 844-512-8999
PA Medical Phone 855-201-7170
PA Medical Fax 855-363-0728



Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756



UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

CHEMOTHERAPY AGENTS PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to member's plan PA helpdesk.
For questions, please call the member's plan PA helpdesk.

CHECK ONE: ☐ Drug dispensed from a pharmacy (pharmacy benefit)
☐ Drug administered in an office or outpatient setting (medical benefit)

MEMBER INFORMATION

Name: _____ Medicaid ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Name: _____ Medicaid ID: _____
NPI: _____ Phone: _____ Fax: _____
Address: _____ City, State, Zip Code: _____

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS NDC lookup tool: <https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp>
- KS HCPCS lookup tool: <https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp>

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

- Complete the **Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests.
- Complete **Section III** for **medication-specific safety criteria** for **ORAL** chemotherapy agents if applicable to the medication requested.
- Complete **Section IV** for **medication-specific safety criteria** for **INJECTABLE** chemotherapy agents if applicable to the medication requested.
- Complete **Section V** if this request is a **renewal**.
- Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:

Oral Agents:

☐ Afinitor ☐ Alunbrig ☐ Braftovi ☐ Cabometyx ☐ Calquence ☐ Cotellic ☐ Farydak ☐ Gilotrif ☐ Ibrance ☐ Idhifa ☐ Imbruvica
☐ Kisqali ☐ Kisqali Femara Co-pack ☐ Lynparza ☐ Mekinist ☐ Mektovi ☐ Ninlaro ☐ Revlimid ☐ Rubraca ☐ Rydapt ☐ Stivarga
☐ Tafinlar ☐ Tibsovo ☐ Tagrisso ☐ Venclexta ☐ Verzenio ☐ Xalkori ☐ Zejula ☐ Zelboraf ☐ Zydelig ☐ Zykadia

Injectable Agents:

☐ Bavencio ☐ Blincyto ☐ Darzalex ☐ Empliciti ☐ Herceptin ☐ Imfinzi ☐ Keytruda ☐ Kyprolis ☐ Lartruvo ☐ Onivyde
☐ Opdivo ☐ Provenge ☐ Rituxan ☐ Rituxan Hycela ☐ Tecentriq ☐ Trelstar ☐ Xofigo

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? ☐ YES ☐ NO

Indication: _____

ICD-10: _____

PATIENT NAME: _____

MEDICAID ID: _____

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?

☐ New☐ Renewal – Proceed to section V.

2. Please document the prescribing physician's specialty.

☐ Hematologist☐ Oncologist☐ OtherA. If other, has the prescribing physician consulted with an oncologist or hematologist?☐ YES – If YES, please document the provider's name, specialty and date of consult:

Provider name: _____ Specialty: _____ Date of Consult: _____

☐ NO3. Has the patient's diagnosis been confirmed by an FDA-approved genetic or confirmatory diagnostic test (if applicable, as defined within the clinical criteria)? ☐ YES ☐ NO- If YES, specify diagnostic test and result: _____4. Does the prescriber attest that the patient's diagnosis is appropriate for treatment with the medication requested? ☐ YES ☐ NO

5. For injectable chemotherapy agents –

- Does the prescriber attest that the medication requested will be used at a dose and frequency consistent with FDA-approved labeling? ☐ YES ☐ NO ☐ N/A – medication is an oral agent

6. Please list all other chemotherapeutic or adjuvant agents that will be used in combination with the medication requested.

7. Please list all medications the patient has previously tried and failed for the treatment of the indication specified in Section I.

*Specify medication name, reason for discontinuation (i.e. inadequate response, allergy, contraindication, intolerance) and dates of previous trial.

Medication nameReason for DiscontinuationDates of trial

8. For female patients –

- Does the prescriber attest that the patient is not pregnant prior to initiation of treatment and must not become pregnant during treatment (pregnancy status must be confirmed by a negative pregnancy test)? ☐ YES ☐ NO- Is the patient breastfeeding? ☐ YES ☐ NO9. Does the prescriber attest that appropriate counseling on effective methods and timeframes of contraception per FDA-labeling will be completed prior to therapy initiation for both male and female patients? ☐ YES ☐ NO**SECTION III: MEDICATION-SPECIFIC SAFETY CRITERIA – For ORAL Chemotherapy Agents**

Select the requested medication from the list below and complete the medication-specific safety criteria questions that follow. If the medication is not listed below, skip section III.

☐ **AFINITOR** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient will not be taking Afinitor tablets and disperz concurrently.

☐ **BRAFTOVI** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient will not be on concurrent moderate or strong CYP3A4 inducers.

☐ **COTELLIC** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient will not be on concurrent moderate or strong CYP3A inducers or inhibitors.

☐ **FARYDAK** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient does not have severe hepatic impairment.

2. Patient does not have a baseline QTcF greater than or equal to 450 msec.

☐ **IBRANCE** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient will not be on a strong CYP3A4 inducer.

☐ **KISQALI** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient will not be on a strong CYP3A4 inducer or drugs known to prolong QT interval.

2. Patient has a baseline QTcF value less than 450 msec.

☐ **KISQALI FEMARA CO-PACK** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient will not be on a strong CYP3A4 inducer or drugs known to prolong QT interval.

2. Patient has a baseline QTcF value less than 450 msec.

PATIENT NAME: _____	MEDICAID ID: _____
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SECTION III (cont.): MEDICATION-SPECIFIC SAFETY CRITERIA – For ORAL Chemotherapy Agents

<input type="checkbox"/> NINLARO – Does the prescriber attest to the following criteria? 1. Patient will not be on a strong CYP3A inducer.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> REVLIMID – Does the prescriber attest to the following criteria? 1. Prescriber, patient and pharmacy are enrolled in the REMS program.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> STIVARGA – Does the prescriber attest to the following criteria? 1. Liver function tests will be monitored prior to initiation of therapy and throughout treatment.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> TAGRISO – Does the prescriber attest to the following criteria? 1. Patient will have a baseline ECG and LVEF evaluated at baseline.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> TIBSOVO – Does the prescriber attest to the following criteria? 1. Patient does not have a diagnosis of Guillain-Barre syndrome 2. Patient will not be on a strong CYP3A4 inhibitor or inducer or drugs known to prolong QT interval.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> VENCLEXTA – Does the prescriber attest to the following criteria? 1. Patient will not be on concurrent strong CYP3A4 inhibitors at initiation or ramp-up phase.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ZEJULA – Does the prescriber attest to the following criteria? 1. Medication will be initiated within 8 weeks of the most recent platinum-based chemotherapy.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ZYKADIA – Does the prescriber attest to the following criteria? 1. Patient will not be on strong CYP3A4 or P-gp inducer.	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION IV: MEDICATION-SPECIFIC SAFETY CRITERIA – For INJECTABLE Chemotherapy Agents

Select the requested medication from the list below and complete the medication-specific safety criteria questions that follow. If the medication is not listed below, skip section IV.

<input type="checkbox"/> BAVENCIO – Does the prescriber attest to the following criteria? 1. Will premedicate with an antihistamine and acetaminophen prior to the first 4 infusions and subsequent infusions as needed.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DARZALEX – Does the prescriber attest to the following criteria? 1. Will premedicate with a corticosteroid, antipyretic and antihistamine.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ONIVYDE – Does the prescriber attest to each of the following criteria? 1. Patient has a baseline bilirubin < 2 mg/dL. 2. Patient will not be on concurrent strong CYP3A inhibitors or inducers.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> RITUXAN – Does the prescriber attest to the following criteria? 1. For Rituxan monotherapy: Prescriber will obtain CBC and platelet counts prior to each Rituxan course. 2. For Rituxan and chemotherapy: Prescriber will obtain CBC and platelet counts at least monthly.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> RITUXAN HYCELA – Does the prescriber attest to the following criteria? 1. Patient will receive at least one full dose of a rituximab product by intravenous infusion prior to initiation of treatment with Rituxan Hycela.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> TRELSTAR – Does the prescriber attest to the following criteria? 1. Patient does not have a known hypersensitivity to triptorelin or other GnRH agonists or GnRH. 2. Medication will be administered under the supervision of a healthcare provider.	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION IV: RENEWAL

1. Does the prescriber attest that the patient has experienced a positive clinical response from continuous treatment with the requested medication? <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Does the prescriber attest that the patient is able to tolerate therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Does the prescriber attest that all additional medication-specific safety criteria (defined within the clinical criteria and above in section III and IV if applicable) is met? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PREScriBER SIGNATURE

☐ I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.

Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.